STATE OF CALIFORNIA

MARRIAGE AND FAMILY THERAPIST EXPERIENCE VERIFICATION

1800 37A-301 (REV. 8/06)

BOARD OF BEHAVIORAL SCIENCES
1625 NORTH MARKET BLVD., SUITE S200, SACRAMENTO, CA 95834
TELEPHONE: (916) 574-7830 TDD: (916) 322-1700
WEB SITE ADDRESS: http://www.bbs.ca.gov

The supervisor must complete this form. Use a separate form for each person verifying hours of supervised experience for licensure as a marriage and family therapist and for each employment setting. Complete a separate form for pre-degree and post-degree hours. ***Make certain that the form is complete and correct prior to signing. Any change should be initialed by the supervisor and is subject to verification.***
Experience verification forms are to be submitted by the applicant with his or her application for licensure.

APPLICANT NAME: _____

SUPERVISOR (*Please type or print clearly in ink.*)

1. SUPERVISOR NAME: Last First Middle

2. ADDRESS: Number and Street

City	State	Zip Code

3. BUSINESS TELEPHONE:

4. NAME OF APPLICANT'S EMPLOYER:

5. ADDRESS: Number and Street

City	State	Zip Code

6. BUSINESS TELEPHONE:

7. a. Was this experience gained in a setting that lawfully and regularly provides mental health counseling or psychotherapy? Yes ☐ No ☐
   b. Was this experience gained in a private practice setting? Yes ☐ No ☐

8. Experience was gained in a setting that provided oversight to ensure that the applicant's work meets the experience and supervision requirements and is within the scope of practice for the profession? Yes ☐ No ☐

9. Dates the experience is being claimed: From _____ (Mo Day Yr) To _____ (Mo Day Yr)

10. How many weeks of supervised experience are being claimed? _____

11. Show only those hours of experience as verified on the weekly summary of hours form. Logged Hours
    a. Individual counseling *(No Min. or Max. hrs. Required)* a. _____
    b. Couples, families, and children *(Min. 500 hrs.)* b. _____
    c. Group counseling *(Max. 500 hrs.)* c. _____
    d. Telephone counseling *(Max. 250 hrs.)* d. _____
    e. Administering and evaluating psychological tests of counselees, writing clinical reports and progress or process notes *(Max. 250 hrs.)* e. _____
    f. Workshops, seminars, training sessions, or conferences directly related to marriage, family, and child counseling *(Max. 250 hrs.)* f. _____
    Total _____

12. Face-to-face supervision: Hours per week Logged Hours
    a. Individual _____ _____
    b. Group *(Group supervision contained no more than 8 persons.)* _____ _____

13. SUPERVISOR: _____ (Type of License) _____ (License Number) _____ (State of License) _____ (Date Originally Licensed)

If M.D., were you certified in Psychiatry by the American Board of Psychiatry and Neurology during the entire period of supervision? Yes ☐ No ☐
Date Board Certified: _____

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

_____ (Date) _____ (Signature)